Tennessee Valley Authority

PPO Medical Plan For Annual Employees

Administered by
BlueCross BlueShield of Tennessee, Inc.

This booklet explains your benefits in general terms. It does not give details on all the terms in the TVA Group Contract. You may contact the TVA Employee Service Center in Knoxville to review the Contract.

- IF YOU HAVE ANY QUESTIONS ABOUT YOUR **ELIGIBILITY FOR HEALTH CARE COVERAGE**, CONTACT THE EMPLOYEE SERVICE CENTER.

TOLL FREE	**(888) 275-8094**
CHATTANOOGA	**(423) 751-8800**
KNOXVILLE	**(423) 632-8800**

- IF YOU HAVE QUESTIONS ABOUT **SPECIFIC CLAIMS, BENEFITS AVAILABLE UNDER THE PLAN OR NETWORK**, CONTACT BLUE CROSS BLUE SHIELD OF TENNESSEE.

RESIDENTS OF ALL STATES	**(800) 245-7942**

- IF YOU HAVE QUESTIONS ABOUT **INFORMATION ON PROVIDERS WITHIN YOUR NETWORK**, INFORMATION IS AVAILABLE AT THE FOLLOWING WEBSITES:

ALABAMA	www.bcbsal.org
KENTUCKY	www.anthem-inc.com
TENNESSEE	www.bcbst.com
BLUE CARD PPO	www.bluecares.com

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SECTION I.

INTRODUCTION

This booklet explains the essential features of the medical plan for annual employees and eligible retirees of the Tennessee Valley Authority. Throughout this booklet, TVA annual employees and retirees are referred to as "subscribers" or "members" of the medical plan.

This is a self-funded benefit plan administered by Blue Cross and Blue Shield. The benefits under the plan and the TVA contribution to the plan are determined through collective bargaining between TVA and the unions representing eligible employees where applicable.

It is very important that you read this booklet carefully and become familiar with your health care program. You need to know how the program works in order to take full advantage of your health care coverage and avoid unnecessary expense. You will have to make important decisions regarding the health care provider you use and the settings in which you receive services. ***Benefits may be reduced when the guidelines are not followed.***

The official plan document is available for review by all members of the plan. This document can be examined in the Benefit Services Office, Knoxville, during normal business hours. You may obtain a copy of this document by submitting a written request to Benefit Services, ET 8D-K, Knoxville. A reasonable charge may be made for all copies provided.

PPO NETWORKS

This medical plan uses a preferred provider organization (PPO) network provided by Blue Cross Blue Shield. Blue Cross Blue Shield has entered into agreements with selected hospitals, ambulatory surgical facilities, physicians, and other health care practitioners to provide reasonably priced medical care to subscribers of the medical plan. The health care providers and agencies that have contracted with Blue Cross Blue Shield are referred to as "In-Network" or "preferred" providers. These health care providers have agreed to certain cost containment features, like a set fee structure, that encourage the use of appropriate alternatives to costly hospitalization. Preferred physicians also have agreed to accept Blue Cross Blue Shield's negotiated fees ***as payment in full except*** for deductibles, coinsurance, and payment for any non-covered services.

THE NETWORKS TO BE USED:

In order to receive in-network coverage while at home or out of state, TVA employees and eligible subscribers should consult the table below.

At the intersection of the subscriber's home state, located horizontally across the top of the table, and the point of service, located vertically down the table, the appropriate in-network plan is identified.

Example. Employees that live in Tennessee should use the Blue Preferred Plan for health care received in Tennessee, but those same employees should use the Blue Card PPO Program if medical care is required in any other state.

← Subscriber's Home State →

	Tennessee Resident	**Alabama Resident**	**Kentucky Resident**	**Mississippi Resident**	**Any Other State**
Tennessee	**Blue Preferred**	Blue Card PPO (in TN)	Blue Card PPO (in TN)	Blue Card PPO (in TN)	Blue Card PPO (in TN)
Alabama	Blue Card PPO (in AL)	**PMD**	Blue Card PPO (in AL)	Blue Card PPO (in AL)	Blue Card PPO (in AL)
Kentucky	Blue Card PPO (in KY)	Blue Card PPO (in KY)	**Option 2000**	Blue Card PPO (in KY)	Blue Card PPO (in KY)
Mississippi	Blue Card PPO (in MS)	Blue Card PPO (in MS)	Blue Card PPO (in MS)	**HealthLink**	Blue Card PPO (in MS)
Any Other State	**Blue Card PPO**	**Blue Card PPO**	**Blue Card PPO**	**Blue Card PPO**	**Blue Card PPO**

To find PPO providers in the Blue Card network in any other state, call 1-800-810-BLUE (2583).

ADVANTAGES OF USING IN-NETWORK PROVIDERS:

No claim forms to be filed because in-network providers are required to submit claims on behalf of patients who are covered under this medical plan.

Payment at the time of service may be minimal or not required at all because the in-network provider can only require payment for the deductible and coinsurance amounts. Many in-network providers require no payment at the time of service and wait until the claim has been processed before billing the patient for the patient's share of the expense.

Patient financial liability is limited because the in-network providers cannot bill patients for charges in excess of the amount allowed by Blue Cross-Blue Shield, except for deductible, coinsurance, and charges for non-covered services. For example, the in-network physician charges $100 for a covered service and Blue Cross-Blue Shield has an agreed fee of $50 for that service. The physician must accept $50 as payment in full for that service (with a combination of payment from the plan and the patient's coinsurance) and cannot bill the patient for the $50 above the allowable amount.

Plan benefits are paid directly to the in-network providers.

When you use preferred providers, you save money for yourself and help hold down the costs of subscribing to this medical plan. Because the preferred providers have agreed to special pricing arrangements and cost containment features, the medical plan can provide a higher level of benefits for covered services.

SECTION II.

YOUR COST CONTAINMENT FEATURES

PRE-ADMISSION CERTIFICATION

If hospitalization is recommended for an eligible member of this medical plan, it is the subscriber's responsibility to inform the health care provider that pre-admission certification is required. The provider will contact Blue Cross Blue Shield with details of the proposed hospital admission. Medical personnel, under the direction of the Blue Cross Blue Shield, shall determine if the hospital admission is appropriate. The purpose is to identify the most appropriate time and place for the member to receive care. The member's physician will be promptly notified of the results of the pre-admission review.

Certification for a hospital admission is valid for 30 days. If the admission does not occur within 30 days, for any reason, the member must obtain another certification.

Pre-admission certification is not required for emergency or maternity care. Emergency admissions must, however, be reported within 24 hours or one working day to Blue Cross Blue Shield.

Pre-admission certification is not confirmation of your coverage or of benefits to be provided. Payment of benefits is subject to the terms of the plan, including limitations and exclusions, and to the member's eligibility and benefits at the time the service is rendered.

SECOND SURGICAL OPINION

Second opinions are encouraged for elective surgical procedures but there are no requirements for second opinions. Charges for a second opinion and for a third opinion, if necessary, are paid at the percentage stated in the Benefits Summary.

CONCURRENT UTILIZATION REVIEW

When a member is in the hospital, a concurrent utilization review process will be conducted to assure that medically necessary health care services are delivered during the hospitalization, and that the services provided meet local community standards of quality and are consistent with the member's needs. The goal of concurrent utilization review is to encourage the appropriate use of hospitalization.

If the review process determines continued hospital care is not necessary, the physician and hospital will be notified by telephone of this decision. Normally, the member's physician will notify the member of the decision immediately and discuss either (1) discharge from the hospital or (2) the additional information regarding the case that he or she will provide to Blue

Cross Blue Shield so that Blue Cross Blue Shield may reconsider the decision. ***The financial impact on the member in these circumstances may be substantially different depending on whether or not the period of hospitalization was in a designated Preferred hospital.***

- ***If the period of hospitalization was in a preferred facility*** and there is a decision that any part, or all, of the hospitalization period was not medically necessary, the member will not be held responsible for the period of unnecessary hospitalization.

NOTE: If you choose to remain hospitalized beyond the date of discharge recommended by your physician, you may be held financially responsible for that period of unnecessary hospitalization even if you are in a Preferred hospital.

- ***If the hospitalization was in a Non-Preferred facility*** and there is a decision that any part or all of the hospitalization was not medically necessary, the member may be financially responsible for payment of the hospital charges which occurred during the unnecessary hospitalization period.

NOTE: Members may want to discuss with their physicians alternative settings for continuing treatment. The choice of providers may significantly impact the amount a member is required to pay for medical care.

SECTION III.

(ALL ITEMS IN THIS SECTION ARE HANDLED BY TVA)

ELIGIBILITY AND COMMENCEMENT OF COVERAGE

WHO IS ELIGIBLE?

- Full-time Annual Employees and their eligible dependents;
- Part-time Annual Employees regularly scheduled to work 16 or more hours per week and their eligible dependents;
- Eligible Retirees and their eligible dependents that are **not eligible for Medicare hospital insurance**, provided the retiree was actively enrolled in a TVA-sponsored medical plan on the last day of his/her active employment.

WHO IS AN ELIGIBLE DEPENDENT?

Eligible dependents are the employee or retiree's:

- ***Spouse***;
- ***Natural or adopted child who is unmarried and is under the age of 19.*** The subscriber must provide at least 50 percent of the child's support or be required by divorce decree or other court order to provide medical coverage for the child. The child must not be employed on a full-time basis (30 hours or more per week) except during school vacations. Coverage can be continued to the 25th birthday provided that the dependent is a full-time student and satisfies the other conditions listed above.
- ***Foster child, stepchild, or child for whom the member is legal guardian or for whom the member has legal custody and who is unmarried, under the age of 19 and living with the member.*** The requirement that the child be living with the subscriber will be waived if the child is attending school full-time but would otherwise live with the subscriber. The child must depend upon the member for at least 50 percent of his/her support and must not be employed on a full-time basis (30 hours or more per week) except during school vacations. Coverage can be continued to the 25th birthday provided that the dependent is a full-time student and satisfies the other conditions listed above.

  If there is a change in the legal status of a dependent, TVA's Employee Service Center must be furnished with copies of the actual legal papers with the final decree from the respective court or legal placement papers issued by the authorized agency are required.

In cases of legal custody or legal guardianship, no benefits are payable for services rendered to a child for any condition during the first 90 days after the member receives legal custody/guardianship of the child. No benefits are payable for any condition, disease, or injury which was diagnosed prior to the effective date of the legal custody/guardianship for the first six months after the member receives legal custody/guardianship.

SPECIAL CIRCUMSTANCES

Coverage for dependent children may be continued past the age limit if they are unable to support themselves because of physical handicap or mental retardation that began before reaching the dependent limiting age. A physician must certify the disability. TVA must receive this certification within thirty-one (31) days prior to the date the coverage would otherwise end. Contact the Employee Service Center for the certification form.

A dependent child can be covered under only one TVA-sponsored family medical plan.

TVA will not contribute to the two family medical plans covering the same family. If husband and wife are eligible for coverage, each may select individual coverage or one may select family coverage.

HOW TO ENROLL

Employees

Employees must enroll within 31 days of becoming eligible as a new employee or transfer to an eligible position.

Employees must complete an enrollment form (Form 9198, available electronically) and return it to either the Human Resources Office or the Employee Service Center. An Enrollment Package may be obtained from the Human Resources Office. You must supply information on your dependents if you are applying for family coverage. ***If accurate information about your dependents is not provided, their claims will be delayed until dependent information is provided.***

If you do not enroll within the 31-day period after becoming eligible, you can not enroll until the annual open enrollment period unless you have a family status change as defined by the Internal Revenue Service.

RETIREES

Eligible retirees must complete a retiree medical application (Form 17328, available electronically or from the Employee Service Center) and return it to the employee Service Center by the end of the month in which employment ends. Information on dependents must be provided if applying for family coverage. ***If accurate information about your dependents is not provided, their claims will be delayed until dependent information is provided.***

Retiring employees must apply for medical coverage at the time of termination. If coverage is not requested at that time, retirees will not be given another opportunity to enroll in medical coverage.

NAME AND ADDRESS CHANGES

It is important that TVA has your correct name and address to make sure claims are paid properly and to prevent delays in processing your claims. You should change your address through the TVA intranet or notify the Employee Service Center.

DEPENDENT CHANGES

Each time there is a change in your marital status or a change in the eligibility of a dependent child (e.g., marriage, employment, or change in student status), you must notify the employee service center so that enrollment records may be corrected. If claims are paid under this plan for a dependent who is later found to be not eligible for coverage, you will be responsible for reimbursing the plan for those benefits paid.

Employees should submit a Status change Form (form 17312, available electronically or from the Employee Service Center) to the Employee Service Center as changes occur. Employees are also responsible for reviewing dependent information provided annually during the open enrollment period and reporting any needed corrections.

Retirees should contact the Employee Service Center to report marital status or dependent changes. Retirees MUST notify the Employee Service Center if the retiree or a covered dependent becomes eligible for Medicare. Retirees and their dependents that are eligible for Medicare may not be covered under this plan and coverage must be transferred to a Medicare Supplement plan available through TVA.

HOW TO CHANGE COVERAGE

You can change your level of coverage (individual or family) during the plan year if you have a family status change as defined by the Internal Revenue Service. Otherwise, ***you may only make these changes during the annual enrollment period.*** You must submit a family status change form within 31 days of the change. This form may be obtained from your Human Resource Office of the Employee Service Center.

WHEN COVERAGE STARTS

Benefits will not be provided for a new or a newly eligible employee and their dependents for treatment of any illness, injury, or condition (other than pregnancy) which was diagnosed prior to the effective date of coverage under this plan until the employee's coverage has been in effect for six months. You must also be subject to this waiting period if you re-enroll in this plan after a break in coverage under a TVA Medical Plan.

PORTABILITY

The TVA Medical Plan gives credit under certain conditions for the time covered under previous health benefit program coverage. Such "Creditable Coverage" may be used to reduce the waiting period for Pre-Existing Conditions. However, it will be the Member's responsibility to advise the Employer of any Creditable Coverage and provide any required documentation. The Employer, in turn, will advise the member as to the date of the Pre-Existing Condition limitation ends. Check with the Employee Service Center or Blue Cross Blue Shield if you need additional information. Blue Cross Blue Shield also furnishes certificates of "creditable coverage" to those leaving the plan. These may be used to get "creditable coverage" for other plans.

SECTION IV.

YOUR MEDICAL PLAN BENEFITS

BENEFITS SUMMARY

The Benefits Summary in this section describes benefits you are entitled to under this medical plan.

NOTE: Under no circumstances does a member acquire a vested interest in continued receipt of a particular benefit or level of benefits. Benefits shall be determined according to the benefit terms in effect when an expense is incurred. Benefits may be amended at any time in accordance with applicable provisions of this plan.

(90% *IN-NETWORK*)	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual Deductible	$200 Individual $400 Family	$200 Individual $400 Family
Hospital Deductible	None	$400 per admission separated by 90 days
Co-Insurance for Facility and Physician Expenses	90% Plan pays 10% Subscriber pays	70% Plan pays 30% Subscriber pays
***Co-Insurance for Other Expenses**	80% Plan 20% Subscriber pays	80% Plan 20% Subscriber pays
Annual Out-of-Pocket Maximum	$1,500 Individual $3,000 Family	$5,000 Individual $10,000 Family

(80% In-Network)	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual Deductible	$300 Individual $600 Family	$300 Individual $600 Family
Hospital Deductible	None	$400 per admission separated by 90 days
Co-Insurance for Facility and Physician Expenses	80% Plan pays 20% Subscriber pays	70% Plan pays 30% Subscriber pays
***Co-Insurance for Other Expenses**	80% Plan pays 20% Subscriber pays	80% Plan pays 20% Subscriber pays
Annual Out-of-Pocket Maximum	$2,500 Individual $5,000 Family	$5,000 Individual $10,000 Family

(70% In-Network)	**IN-NETWORK**	**OUT-OF-NETWORK**
Annual Deductible	$400 Individual $800 Family	$400 Individual $800 Family
Hospital Deductible	None	$400 per admission separated by 90 days
Co-Insurance for Facility and Physician I Expenses	70% Plan pays 30% Subscriber pays	50% Plan pays 50% Subscriber pays
***Co-Insurance for Other Expenses**	80% Plan pays 20% Subscriber pays	80% Plan pays 20% Subscriber pays
Annual Out-of-Pocket Maximum	$2,500 Individual $5,000 Family	$5,000 Individual $10,000 Family

*Co-Insurance for Other Expenses are ambulance, durable medical equipment (DME), Temporomandibular Joint Dysfunction (TMJ), routine immunizations, and therapeutic injections and allergy serums.

ELIGIBLE EXPENSES

The following sections describe the services and supplies covered under this plan. The benefits for covered services or supplies shall be determined by reference to the Benefits Summary and to the classification of expenses. Benefits are subject to existing deductibles and are paid based on the negotiated rate as determined by Blue Cross Blue Shield or the charges billed, whichever is lower and determined to be medically necessary by BCBST. Only the lower amount between the charges billed or the negotiated rate for a service will be considered an eligible expense; any portion of the charge which is more than the lower amount of either of these fees is not covered under this plan.

Allergy Testing

Is covered except for food allergy testing.

Ambulance Service

Local ground ambulance rates up to 100 miles. If an air ambulance or other type ambulance is used, the plan pays only up to the amount it would have paid for local ground ambulance service. If a one way trip is more than 100 miles, only the first 100 miles will be considered as an eligible expense.

Audiological Tests

As determined eligible by BlueCross BlueShield, for medical reasons other than hearing loss.

Case Management

Services will be offered to individuals with chronic or catastrophic illnesses or injuries that will link individual and family caregivers with the appropriate medical care and services. Case Management involves the systematic process of assessing, planning, coordinating, implementing and evaluating care through which multiple health and psycho-social needs of the member are met. Services will be offered for those individuals participating in an in-patient rehabilitation, recipients of major organ transplants, medical or behavior conditions that have a high risk, and members with a specific targeted diagnosis.

The following are some examples of the conditions that constitute chronic or catastrophic illness or injury and might indicate intervention of case management:

a. Neonatal Conditions
b. Obstetric Conditions
c. Transplant (Bone Marrow Transplant, organ)
d. Neurological Conditions
e. Cardiovascular Conditions

f. Respiratory Conditions
g. Malignancy
h. Trauma
i. Chronic Conditions
j. Renal Conditions
k. Acquired Immune Deficiency Syndrome
l. Brain Injury
m. Other major injuries or serious illnesses where extended treatment or hospitalization is indicated.

Chiropractic Coverage

Benefits are available up to $1,000 (including deductible) per member per calendar year for services and supplies furnished or provided by a licensed Chiropractor only in connection with massage or spinal manipulation for dislocation, subluxation or misplacement of vertebrae, or strains and sprains of soft tissue related to the spine.

Cochlear Implants

Dental Services

This plan does not cover dental care. Plan benefits are available for dental work needed as a result of an accidental injury to the jaw, natural teeth, mouth or face. To be covered, the accident must occur on or after the date the injured member's coverage begins. Treatment must be received within 36 months of accident. Related X-rays within the 36-month period are also included. Facility charges for medically necessary health conditions are covered. All follow-up treatment is at 80% of fee schedule.

Durable Medical Equipment

Blue Cross Blue Shield determines eligible medical equipment, which includes:

a. Orthopedic braces (except corrective shoes and arch supports), crutches and prosthetic appliances such as artificial limbs and eyes, including their replacement, repair, or adjustment.
b. Rental of a manual wheelchair, hospital bed, or an iron lung for temporary therapeutic use. Oxygen and rental of equipment for its administration.
c. Dressings, casts, and splints.
d. One set of eyeglasses or contact lenses required as a result of or directly related to intraocular surgery or ocular injury.

After considering the cost and availability, Blue Cross Blue Shield decides whether to buy or rent the equipment.

Emergency Services

Benefits will be provided as specified in the schedule of Benefits for Emergency Services received in a Hospital Emergency department by the attending Physician.

Prior authorization for emergency services will not be required. However, once the subscriber's medical condition has stabilized, pre-admission certification will be required for continuing inpatient care or transfer to another facility. ***Benefits will be reduced or denied if pre-admission certification is not obtained.***

Hospital/Facility Other Provider Charges

1. Inpatient Hospital Charges for bed, board and general nursing care up to the hospital's most prevalent semi-private room rate, and room in an approved special care unit (a special care unit provides intensive care to the critically ill).

This plan provides benefits for the following services and supplies received in and billed by a hospital;

- **a.** use of operating, delivery and treatment rooms;
- **b.** drugs and medicines, including take home drugs;
- **c.** sterile dressings, casts, splints and crutches;
- **d.** anesthetics and their administration;
- **e.** diagnostic service;
- **f.** therapy services; and
- **g.** whole blood, blood component, and blood derivatives (unless donated or replaced).

The plan does not pay for the day of discharge unless admission and discharge occur on the same day.

2. Outpatient Services - The following services and supplies provided in a hospital's outpatient department or facility other provider;
   - a. treatment of accidental injuries;
   - **b.** treatment of an illness that occurs suddenly and requires immediate medical attention;
   - **c.** removal of suture, anesthetics and their administration, and other surgical services provided by a hospital employee other than the surgeon or assisting surgeon;
   - **d.** drugs, crutches, and medical supplies; and
   - **e.** whole blood, blood components, and blood derivatives (unless donated or replaced);
   - f. cardiac rehabilitation services must begin within eight weeks following discharge from a hospital following the members confinement for:
     - myocardial infarction
     - coronary artery bypass surgery

- percutanious transluminal coronary angioplasty
- organ transplant surgery (heart or heart/lung)
- aortic or mitral valve surgery

Benefits will be limited to ONE cardiac rehabilitation program within a 12 month period. Rehabilitation services are covered for three (3) visits per week up to twelve (12) weeks for a total of thirty six (36) visits, whichever comes first.

3. Partial Hospitalization/Intensive Outpatient Service - Benefits are only available through case management if medically necessary.

4. Pre-Admission Testing - Certain tests and studies are commonly required before a scheduled hospital surgical admission. This plan covers all such tests and studies performed or accepted by a hospital within seven days before a hospital admission when billed by the hospital.

5. Routine Nursery Care - The Plan covers pregnancy and childbirth on the same basis as an illness.
Benefits are provided for the facility's charge for routine nursery care of an eligible newborn when the charge is included as a part of the mother's hospital bill or when billed in the eligible newborn's name under a family contract.

6. Skilled Nursing Facility - Benefits are provided for inpatient care in a skilled nursing facility.

7. Hospice Care - Is an alternative to lengthy inpatient treatment for terminally ill patients. The patient's physician must establish a plan of treatment. An approved hospice must provide the services.

The following services are not covered under "Hospice Home Care Benefits":

a. charges for services greater than the rate set in advance by the participating or approved hospice agreement;
b. housekeeping services, delivered or prepared meals, and convenience and comfort items not related to the palliation or management of the patient's terminal illness;
c. comfort items not directly related to relieving pain or managing the patient's terminal illness;
d. supportive environmental items such as air conditioners, air fresheners, ramps, handrails, or intercom systems;
e. transportation, chemotherapy, radiation therapy, enteral and parenteral feeding, private duty nursing, home hemodialysis, and other service supportive to research, diagnosis, and lengthening patterns of treatment;
f. visits made to the home by the physician;
g. inpatient care at any facility. This includes inpatient care provided in a hospice, hospital, skilled nursing facility, intermediate care facility, or any other institution;

h. psychiatric care;
i. services provided by volunteer agencies or pastoral counseling services, and;
j. items, services, or expenses not specifically stated as covered under this benefit.

8. Home Health Care - Benefits are provided for services when prescribed by the member's physician and performed and billed by a home health care agency:
   - part-time or intermittent nursing care by a visiting RN or LPN;
   - physical therapy and respiratory therapy by persons licensed to perform such service;
   - oxygen and its administration; and
   - diagnostic services.

Human Organ Transplant Coverage

Benefits under this special coverage are provided instead of , not in addition to, the benefits described in other sections of this booklet. This endorsement must be in effect for 12 months before benefits are payable. In the event a member requires a covered human organ transplant, benefits begin five days prior to the scheduled transplant and extend for a year following the surgery, or up to 370 days.

Benefits will be paid for covered medical expenses related to transplants of the following organs:

Heart
Heart/Lung
Lung (single and double)
Liver
Pancreas
Small Bowel
Small Bowel/Liver

Health care benefits up to $1,000,000 will be paid for expenses related to covered transplants during a subscriber's lifetime.

Organ transplant coverage includes expenses incurred for donor organ procurement and all inpatient and outpatient hospital/medical expenses for the transplant procedure and related pre and post-operative care, including immunosuppressive drug therapy.

Meals and lodging expenses are covered up to a $150 daily maximum. The aggregate limit for all travel expenses is $10,000 per Covered Procedure and is included in the $1,000,000 Maximum.

Only limited human organ transplants are covered. Coverage excludes artificial implants and non-human transplants, as well as any services or supplies Blue Cross and Blue Shield considers experimental or investigative.

Notwithstanding any other exclusions, the following service and supplies are not covered under this Section:

1. services, supplies, and equipment BCBS determines to be not medically necessary;
2. expenses more than five (5) days before a transplant procedure or more than twelve (12) months after such a procedure;
3. charges which result because of a patient's underlying medical condition or complications of such a condition;
4. charges which result because of complications of a covered transplant procedure, unless BCBS determines that the complications are an immediate and direct result of the transplant procedure;
5. expenses related to any artificial or mechanical organ implant;
6. expenses related to the transplantation of any non-human organ or tissue;
7. expenses for blood donor fees;
8. expenses related to a transplant procedure performed before the effective date of coverage under this section;
9. expenses which are eligible to be repaid under any private or public research fund, regardless of whether the patient applied for or received such payment;
10. payment to an organ donor or the donor's family as compensation for an organ or for the written consent needed to get an organ;
11. travel expenses, including professional charge for travel time, except as described earlier under "What is Covered";
12. fees charged by interns, residents, fellows, and other physicians who are salaried employees of the hospital or other facility
13. any expense (other than for experimental and investigative treatment) specifically excluded in benefit plan description;
14. items, services, or expenses not specifically stated as covered under this section;
15. expenses covered by;
    - any group, blanket, or franchise insurance coverage;
    - contractor, group, or individual practice plans, or other prepaid coverage;
    - labor-management trusteed, union welfare, employer organization, or employee benefit organization plans; or
    - tax supported or government programs, except State-provided Medicaid coverage;
16. expenses for services, supplies, or treatment received in a hospital owned or operated by the Federal government or agency thereof, except as required by applicable law.

Mental Health Case Management

Behavioral case management will be offered to individuals in inpatient levels of care when services determine that alternative treatment is medically necessary, cost effective and/or not otherwise specified as a covered service. Contractor will identify potential cases for inclusion in the case management program, develop or evaluate proposed treatment plans and offer the member alternative benefits.

Occupational Therapy and Hand Therapy

Services provided by an occupational therapist for treatment of stroke or injury is a covered service.

Physician/Professional Other Provider Charges

1. Surgery
2. Office Visits
3. Consultations
4. Surgeons - when medically necessary for limited procedures.
5. Assistant Surgeons - for limited procedures when staff physicians are not available.
6. Anesthesia Services
7. Second Surgical Opinions
8. Maternity Care
9. Diagnostic Services, including;
    - x-ray and other radiology services;
    - laboratory and pathology services;
    - cardiographic, encephalographic, and radioisotope tests; and
    - nuclear magnetic resonance imaging (M.R.I) for procedures approved by Blue Cross and Blue Shield in accordance with established guidelines and any injection and supplies necessary for the above mentioned procedures.
10. Therapy Services
    - radiation therapy;
    - chemotherapy;
    - dialysis treatment;
    - physical therapy;
    - speech therapy for stroke ad accidental brain injury cases only;
    - occupational therapy and hand therapy for stroke and accidental injury cases;
    - vision therapy.
11. Private Duty Nursing if:
    - the attending physician orders the service;
    - the nurse is not a relative and does not normally live in the patient's home;
    - special care is medically necessary; and
    - the level of care required could not be provided by the hospital's regular nursing staff.
12. Annual Physicals
    - $250 maximum dollars are available in one calendar year. All charges are subject to the $200 deductible.
    - $250 maximum can be one (1) visit or several within the same calendar year.
    - Routine pap smears will not apply to the $250 physical maximum (Already a covered benefit under the current Plan.)
    - Routine mammograms will apply to the $250 physical maximum.

- Diagnosis of work physical, insurance physical, etc. will be eligible to apply to the $250 routine physical exam maximum.
- Flu shots will apply to the $250 physical exam maximum.
- Routine hearing exams will apply to the $250 physical exam. However, benefits for hearing aids will not be available.
- Routine exams for evaluation of possible "braces" will not be an eligible expense (considered dental).
- Routine foot care will be eligible; however, orthotics will not be eligible.
- Routine eye exams will not be eligible.

Prescription Drugs

Benefits are only available for prescription drugs dispensed through a physician's office, hospital or other eligible facility. All other out of hospital prescription drugs will be processed and paid by an external pharmaceutical benefits management vendor to the extent covered under separate agreement between TVA and that company.

Psychiatric Treatment (including substance abuse)

Psychiatric Maximum Benefit - Includes benefits paid for In-Network, Out-of-Network, and Out-of-Service Area services (including substance abuse).

All Options

- Annual maximum for outpatient treatment - 30 visits per calendar year.

- Lifetime maximum for inpatient treatment - 150 days per lifetime.

Routine Immunizations

This plan covers the following routine immunizations: Diphtheria, Tetanus, Pertussis, Poliomyelitis, Measles, Hepatitis B, Rubella, Mumps and Hib (for Meningitis, Epiglottis and Joint Infections).

Speech Therapy

In cases of stroke or accidental brain injury cases , if such services are prescribed by a physician.

Temporomandibular Joint Dysfunction (TMJ)

This plan covers office visits (including exams and history, x-rays of the joint, and diagnostic study casts), and physical medicine (physical therapy). Many surgical procedures for medical treatment of TMJ will be covered to the same extent as any other surgical procedure. There are also benefits for other types of TMJ Class III Expenses.

(Orthodontic treatment is not covered). Patients or their physicians should contact the BCBS with a treatment plan to determine if services are eligible for benefits.

Therapeutic Injections

SECTION V.

WHAT IS NOT COVERED

***This plan* DOES NOT *provide benefits for*:**

1. Services or supplies not prescribed or performed by a physician or professional other provider;

2. Services or supplies which are not medically necessary as determined by Blue Cross Blue Shield;

3. Services rendered by other than a hospital facility, facility other provider or listed other provider;

4. Services or supplies provided in connection with an experimental or investigative treatment, drug, procedure, or supply;

5. Any work related illness or injury or any services covered by Worker's Compensation or employer's liability laws;

6. Services or supplies furnished without cost under the laws of any Federal or foreign government except Medicaid coverage provided by the State;

7. Illness or injury resulting from war and occurring after this coverage begins;

8. Services for which the patient is not legally obligated to pay;

9. Services or supplies received in a dental or medical department maintained by or on behalf of an employer, mutual benefit association, labor unit, trust, or similar group;

10. Services or supplies provided in connection with a surgical procedure primarily to improve appearance. The plan will cover surgery needed to restore a bodily function or correct deformity if the condition occurs while covered as a member under this contract which results from:

- **a.** disease;
- **b.** birth defect;
- **c.** surgery (excluding non-functional scar revision);
- **d.** accidental injury; or
- **e.** removal of breast implants if leakage can be documented;

11. Services provided by any member of the patient's immediate family by blood or marriage;

12. Services provided before the patient's coverage begins

13. Services covered under any other group blanket or franchise insurance coverage, any other Blue Cross Blue Shield group contract, other health insurance plan, union welfare plan, labor management trusteed plan, tax supported or government programs except Medicaid coverage;

14. Personal hygiene and convenience item (for example air conditioner, humidifiers, hysival fitness equipment, hot tubs, swimming pools and tanning beds);

15. Telephone consultations, charges because a person fails to keep a scheduled appointment, or charges to complete a claim form;

16. Hospital admissions which are primarily for diagnostic studies, unless the admission has been pre-certified;

17. Custodial care, such as help in walking, getting in and out of bed or any service that could be performed by non-professional personnel;

18. Charges for routine foot care or the treatment of flat feet, corns, bunions, calluses, toe nails, fallen arches, weak feet, and chronic foot strain, which exceed the annual limit as stated in the Benefits Summary, unless treatment is an approved surgical procedure;

19. Charges for routine physical examinations and screening examinations which exceed the annual limit as stated in the Benefits Summary, except for pap smears;

20. Physician's charges for well-baby care, unless otherwise stated;

21. Services or supplies for dental care, unless related to the treatment of an accidental injury to a natural tooth or except as specified;

22. Eyeglasses, contact lenses, and examinations for the fitting of eyeglasses and contact lenses, (these charges cannot be used under the annual physical benefit) except as specified;

23. Hearing aids and examinations for and the fitting of hearing aids;

24. Hospital admissions primarily for physical therapy;

25. Surgery to change sex and related treatment;

26. Immunizations unless otherwise stated under the routine physical guidelines;

27. Services or supplies for, or in connection with, artificial insemination, in vitro fertilization, or any other procedure used to create a pregnancy;

28. Services covered under Medicare except where prohibited by Federal law;

29. Services, supplies, or charges for:

30. speech therapy, and occupational therapy (except as specified), recreational therapy, rehabilitative therapy (except as specified), or educational therapy, or for;

31. forms of non-medical self-care or self-help training and any related diagnostic testing or for social services;

32. Services or supplies for a radial keratotomy or similar procedure for the correction of a refractive error of the eye;

33. An artificial heart, liver, lung, or pancreas or any other artificial organ or any associated expense;

34. Service or supplies for the reversal of sterilization;

35. Services or supplies incurred after a concurrent review determines the service and supplies are no longer medically necessary;

36. Charges in excess of the maximum allowable charge for a service or supply;

37. Services or supplies for treatment of obesity, and/or inpatient treatment of bulimia, anorexia, or other eating disorders which consist primarily of behavior modification, diet and weight monitoring unless determined by Blue Cross Blue Shield to be medically necessary for surgical intervention procedure due to life threatening conditions/complications related to morbid obesity.

38. Expense for a private hospital room exceeding the institution's most prevalent semi-private charge;

39. Physician's charges for dental surgery unless related to treatment of an accidental injury to a natural tooth, facility charges are covered if medically necessary;

40. Expenses incurred for services rendered to a child for any condition during the first 90 days after the member receives legal custody/guardianship of the child;

41. Expenses incurred for services rendered to a child for the first six months after the member receives legal custody/guardianship of the child for any condition, disease or injury which was diagnosed prior to the effective date of the legal custody/guardianship;

42. Expenses related to life threatening conditions or complications related to morbid obesity;

43. Services rendered for or in connection with physical therapy which consists primarily in the application, supervision or direction in the use of exercise or physical fitness equipment - whether or not such services are rendered by an eligible provider;

44. Any balance of charges , deductibles, or coinsurance resulting from a member's failure to comply with applicable requirements of any other group contract including: prior authorization, surgical opinion consultation, outpatient surgery, or concurrent care review programs;

45. Payment in excess of $1,000 (including deductible) per member per calendar year for services and supplies furnished by a chiropractor;

46. Therapy not prescribed by a physician and not directly performed by a licensed therapist, or not prescribed by a physician and not performed under the direct supervision of a physician (if the therapy is performed by a licensed physical therapist.);

47. Orthotics;

48. Independent practitioners, psychological examiners, and master social workers (MSW) are not covered (see list of eligible providers in Definition Section);

49. The following services and supplies are not eligible for benefits: orthodontic treatment (braces); prosthodontic treatment (dentures, bridges); restorative treatment (fillings, crowns); full mouth rehabilitation (restorations, extractions); and equilibrations (shaving, shaping, reshaping teeth) unless related to accidental injury to a natural tooth;

SECTION VI.

DUPLICATE COVERAGE

COORDINATION OF BENEFITS

Coordination of Benefits is simply a way of dividing liability between the two plans so that the employee is able, whenever possible, to meet his health care expenses in full (subject to applicable deductions) - and not collect more than the actual costs. Coordination of Benefit Information must be updated annually**. Employees will receive a letter to update this information.**

In processing a claim where two or more group health plans exist, who pays first? And how much?

The coordination of benefits provision in your health plan coverage is as follows:

1. Any plan which covers the person as an employee or subscriber will be considered primary and must provide benefits before any plan which covers the person as a dependent will provide benefits.
2. For dependent children:

    a. The benefits of the contract of the parent whose birthday falls earlier in a year would pay before those of the contract of the parent whose birthday falls later in that year, if the other plan follows the birthday rule; but

    b. If both parents have the same birthday, the benefits of the contract which covered the parent longer will pay before those of the contract which covered the other parent for a shorter period of time.

    However, if the other contract does not have the rule described above, but instead has a rule based upon the sex of the parent, and if, as a result, the contracts do not agree on the order of the benefits, the rule in the other contract will determine the order of benefits.

3. If the dependent child's parents are divorced (not remarried), the following applies:

    a. Natural parent with custody pays first; then

    b. Natural parent without custody pays secondary;

    c. Regardless of which parent has custody, whenever a court decree specifies the parent who is financially responsible for the child's health care expenses, the coverage of that parent pays first.

- When none of the above applies, the coverage you have had the longest time pays first.

- If you receive more than you should when your benefits are coordinated, you will be expected to repay any overpayment.

OTHER DEPENDENT CHILD ELIGIBILITY ISSUES SHOULD BE DISCUSSED WITH TVA'S EMPLOYEE BENEFIT SERVICE CENTER (1-888-275-8094).

Coordination of benefits prevents duplication and works to the advantage of all members of the group.

SUBROGATION

Subrogation is another method used to prevent duplicate payments in cases in which the patient is injured by the action or fault of another person when payments are made by that person or by his/her insurance plan. It works this way:

1. To the extent that your plan provides or pays benefits, you must repay the plan up to the amount of such benefits where you receive payment from another person or that person's insurance company for medical expenses.
2. Blue Cross Blue Shield on behalf of the plan assumes your legal rights to recovery of any payments for medical expenses paid by the plan because you became ill or were injured by the action or fault of another person. Blue Cross Blue Shield has the right to recover amounts equal to these payment by suit, settlement or otherwise from the person who caused the illness or injury, or his or her insurance company.
3. You must give Blue Cross Blue Shield information and assistance and sign necessary papers. If this is not done or if you settle any claims without Blue Cross Blue Shield's written consent, Blue Cross Blue Shield will be entitled to costs it has in trying to recover payments for medical expenses.

SECTION VII.

OTHER INFORMATION

HOW COVERAGE STOPS

Because you are covered under a master contract with your group, your health care protection stops when your group contract ends. If you cease to be a group member, or for any other reason cease to be eligible for group coverage, your health care protection under the group's contract ends.

TERMINATION OF EMPLOYMENT

If you resign or are otherwise terminated from TVA, your coverage under this plan will continue through the end of the month in which your employment terminates. Further, if you have been covered by this plan for at least three months, you can continue this coverage for an additional one, two, or three months after your employment is terminated. If you elect to continue this coverage, you must make payment in advance to TVA for each month of coverage including that portion of the contribution rate previously paid by TVA. Your coverage will automatically terminate on the last day of the period for which payment of charges has been made to TVA. Contact Employee Accounting, Knoxville, to make arrangements for paying the contributions for this continued coverage.

RETIREMENT

If you retire from TVA, you will need to contact the Employee Service Center about medical coverage available to you and your dependents upon retirement.

APPEALS

Your rights under this plan are legally enforceable. Subscribers should first allow sufficient time (at least (60) days) for Blue Cross Blue Shield to process a claim and notify the patient through an explanation of benefits. If, after discussion with Blue cross Blue Shield, the subscriber believes a benefits claim has not been promptly paid or was improperly denied by Blue Cross Blue Shield, the subscriber should then contact the Employee Service Center regarding the appeals process.

ADMINISTRATORS AND APPEALS COMMITTEE'S DECISION

Decisions and determinations under this plan shall be made within the sound discretion of Blue Cross Blue Shield, for the initial determination, and the appropriate health care committee responsible for the plan under which subscriber is covered, upon appeal. Decisions and determinations of the health care committee are final unless they are determined to be arbitrary and capricious. In matters that are appealed to the health care committee, the health

care committee shall have the authority to waive recovery of any amounts paid incorrectly to, or on behalf of, a subscriber if the incorrect payment was made with respect to an individual who is without fault and where the health care committee determines that recovery would be against equity and good conscience. Such waivers shall be without prejudice to the plan and shall not be viewed as having precedential effect**.**

RIGHTS OF RECOVERY AND REIMBURSEMENT

If Blue Cross Blue Shield makes an error in administering benefits under this program, Blue Cross Blue Shield may provide additional benefits or recover any overpayments from any person, insurance company, or plan. No such error may be used to demand more benefits than those otherwise due under this plan.

LEAVE WITHOUT PAY

If you go on leave without pay and do not expect to be back in pay status at the time of the next payroll deduction for medical coverage, you can continue your coverage by paying the full monthly contribution rate to TVA. You must pay at least one month's contribution, but you may pay for more months in advance. Payment must be received by TVA's Employee Accounting, Knoxville, by the 15th of the month preceding the months for which the payment is applicable. If you should return to pay status before the advance payments are used up, you can request a refund of the unused payment from the TVA Employee Accounting Office, Knoxville.

Service Connected Disability - If you are on leave without pay for a service-connected disability, TVA will pay its portion of your contribution rate for up to 12 months and the employee must pay their portion to continue coverage. After this 12 months, the employee must pay the entire contribution rate (TVA's share and employee's share).

Non-Service Connected Disability - If you are on leave without pay due to a non-work related disability you may be able to continue in the plan for up to six months at no cost to you. Your human resource office must notify Employee Accounting, Knoxville, to continue your coverage under this provision. After this six months, the employee must pay the entire contribution rate (TVA's share and employee's share).

Family Leave - If you are on approved family leave, you may continue your coverage by making payment for the employee portion of your coverage. TVA will continue to pay its portion for your coverage. After approved family leave ends, the employee must pay the entire contribution rate (TVA's share and employee's share).

TERMINATION OF COVERAGE FOR DEPENDENTS

Coverage for a Spouse terminates on the date of legal separation or divorce

Coverage for a dependent child terminates on the date that child cease to be an eligible dependent as defined in this booklet—e.g., on the 25th birthday, if a full-time student, or on the date of marriage or graduation..

Employees and retirees are responsible for notifying the Employee Service Center of these changes.

BENEFITS AFTER COVERAGE ENDS

Benefits will be provided for six months after a member's coverage terminates for any condition which had been diagnosed and for which treatment had begun prior to termination of coverage. This does not apply to dental surgery.

These extended benefits will not be continued if the group contract terminates, unless the former member is hospitalized on the date group coverage terminates, in which case benefits will be provided until maximum benefits are provided or until he or she is discharged, whichever occurs first.

CONVERSION TO DIRECT PAY POLICY

When your, or your dependent's, coverage under this plan terminates, you, or your dependent, may continue protection with Blue Cross Blue Shield on a direct pay basis, regardless of present condition of health. The benefits and costs of direct pay policies differ from the TVA-sponsored medical plans. Contact Blue Cross Blue Shield for information on available options.

PLAN CONTINUATION

While TVA expects and intends to continue this medical benefits plan indefinitely, the plan or any provisions contained therein may be amended or terminated by TVA at any time subsequent to the consent of the applicable union representative where required.

SECTION VIII.

CLAIMS: HOW AND WHEN TO FILE

CLAIMS FOR PARTICIPATING PROVIDER SERVICES

Preferred or in-network providers will file claims directly with Blue Cross Blue Shield. Available benefits will be paid directly to the Provider, and you will receive an Explanation of Benefits (EOB) showing our payment and any balance which remains your responsibility.

CLAIMS FOR NON-PARTICIPATING PROVIDER SERVICES

If a Non-Participating Provider asks you to pay for treatment, ask the provider to give you a Blue Cross Blue Shield form and an itemized statement listing the services received and the charge(s) for each service. You may then submit a claim to us, and available benefits will be paid to you. Be sure to include (1) The patient's name, (2) your subscriber identification and group numbers, (3) treatment dates, (4) the patient's diagnosis, and (5) information about any other health insurance the patient may have.

In addition to using a Blue Cross Blue Shield form, there are two other ways you can help ensure timely response to your claim:

1. Notify TVA and Blue Cross Blue Shield if you have other health insurance.

   In processing a claim where two or more group health programs are involved, benefits are coordinated between the two programs. This coordination allows the patient, whenever possible, to meet his health care expenses and yet not collect more than the actual costs.

   To avoid delays that may occur when we have to ask about your coverage under another plan, be sure to let us know if you become covered under another group health program.

2. Keep TVA advised of your current address.

WHEN TO APPLY FOR BENEFITS

You or you health care provider should file claims as soon as possible after you receive care. If care is received on a continuous basis, your claims should be submitted at least every 30 days.

It is important that you keep separate records of the eligible medical expenses for yourself and each of your eligible dependents since the deductible and the maximum amounts are calculated separately for each of you.

All claims must be submitted no later than two years from the date the service was provided. If coverage is terminated, claims for services performed before termination must be received by us within nine months of the termination date.

RIGHT TO RELEASE INFORMATION

Certain information is needed to process claims under this plan. In claiming benefits for Covered Services, each Member agrees to give Blue Cross Blue Shield any information they need to process claims. He or she authorizes the Physicians, Hospital, or Other Provider having information concerning the condition or treatment of the Member to release all the necessary information and records to Blue Cross Blue Shield.

Blue Cross Blue Shield has the right to decide what information is needed and obtain from or release such information as is deemed appropriate by Blue Cross Blue Shield to any other organization or person.

CONTRACT INTERPRETATION

As a condition to providing coverage under this plan, it is agreed that whenever Contractor as Contract Administrator makes a determination which is not arbitrary or capricious in the administration of the Contract (including, without limitation, determinations as to whether services or supplies are medically necessary or experimental/investigative) such determinations shall be final and conclusive.

PAYMENT OF BENEFITS

Benefits under this plan may be paid directly to the Provider furnishing Covered Services. However, we also reserve the right to provide benefits to the subscriber or member except as where prohibited by law. Rights of a member under this plan may not be assigned or transferred.

Once covered services are rendered, we will not have any obligation to honor member requests not to pay claims submitted by the provider. We will have no liability with respect to our denial of any such request.

Claims will be processed based upon information available at the time a claim is received. Contractor will not be responsible for over/under payment of claims resulting from incomplete or inaccurate information, provided reasonable efforts are made to obtain and verify relevant facts when claims are submitted.

SECTION IX.

DEFINED TERMS (For additional definitions refer to TVA Master Contract)

1. Accidental Injury means a traumatic injury which, if not immediately diagnosed and treated, could reasonably be expected to result in serious physical impairment or loss.

2. Behavioral Health Care refers to treatment of a Mental or Substance Abuse.

3. Benefit Percentage is the percentage stated in the schedule of benefits that we will pay for a covered service during a benefit period after a member satisfies any deductible.

4. Benefit Period is a calendar year while this Contract is in force during which benefits for Covered Services may be available. Provider charges for such Covered Service(s) are considered incurred on the date they are provided.

5. Billed Charges means the amount a provider charges for services rendered. Billed charges may be different than the maximum allowable charge for services.

6. Blue Card Program means a program established by Blue Cross and/or Blue Shield organizations and the Blue Cross Blue Shield association to process and pay claims for covered services received by a member of a Blue Cross Blue Shield organization from a provider outside the organization's service area with whom the organization does not have an agreement.

7. Blue Preferred Provider is a physician, hospital or other provider that has a contracted with contractor to furnish services and to accept contractor's payment, plus applicable deductibles and co-payment, as payment in full for covered services.

8. Coinsurance means the amount, stated as a percentage of the lesser of the applicable negotiated rate or other method of reimbursement by Blue Cross Blue Shield for a Covered Service that is the responsibility of the Member during the Benefit Period after any Deductible is satisfied.

9. A covered service or supply is a Medically Necessary service or supply stated in this benefit plan description for which benefits may be available.

10. Creditable Coverage is individual or group health coverage of the member prior to his or her enrollment date which may be applied to reduce a member's pre-existing condition waiting period, if any, stated in this plan. Creditable coverage includes coverage under COBRA, a health maintenance organization, Medicare, Medicaid (including TennCare), the Federal Employee Health Benefit Plan, and or a public, government, military or Indian Health Service benefit program.

11. Up to 18 month of Creditable coverage may be applied to reduce the member's applicable pre-existing condition waiting period. However, a period of coverage will not be counted for purposes of reducing a member's pre-existing condition waiting period if there is a break in such coverage of 63 days or more during which the Member was not covered under any Creditable coverage.

12. Custodial Care means care provided primarily for maintenance designed to assist the patient in activities of daily living. It is not provided primarily for its therapeutic value in treatment of an illness or injury. Custodial Care includes, but is not limited to, help in walking, bathing, dressing, feeding, preparation of special diets, and supervision of self-administration of medication not requiring constant attention of medical personnel.

13. Deductible is the dollar amount stated in the Benefits Summary that must be paid for covered services in a benefit period before the Plan will pay benefits. The deductible will apply to the Out-of-Pocket and Family Out-of-Pocket Maximum(s).

14. Dependent

A dependent is the subscriber's:

a) Spouse;

b) Natural or adopted child who is unmarried and is under the age of 19. The employee must provide at least 50 percent of the child's support or be required by divorce decree or other court order to provide medical coverage for the child. The child must not be employed on a full-time basis (30 hours or more per week) except during school vacations. Coverage can be continued to the 25th birthday provided that the dependent is a full-time student and satisfies the other conditions listed above.

c) Foster child, stepchild, or child for whom the subscriber is legal guardian or for whom the subscriber has legal custody who is unmarried under the age of 19 and living with the subscriber in a regular parent-child relationship. The requirement that the child be living with the employee in a regular parent child relationship will be waived if the child is attending school full time but would otherwise live with the employee in a regular parent-child relationship. The child must depend upon the subscriber for at least 50 percent of his/her support and must not be employed on a full-time basis (30 hours or more per week) except during school vacations. Coverage can be continued to the 25th birthday provided that the dependent is a full-time student and satisfies the other conditions listed above.

d) A child is considered a foster child if:

i) TVA receives the application to cover the child within thirty-one (31) days prior to the placement or date the child established residency, whichever is earlier;

ii) The placement is for a minimum of twenty-five (25) days per month and expected to exceed one year; and

iii) The medical expenses of the child are not covered by any other group coverage or by the agency through which the child was placed.

15. Durable Medical Equipment means equipment which can only be used to serve the medical purpose for which is prescribed; and

    a. Is not useful to the patient or other person in the absence of illness or injury;

    b. Is able to withstand repeated use; and

    c. Is appropriate for use within the home.

    d. Such Equipment will not be considered a Covered Service, even if it is prescribed by a Physician or Other Provider, simply because its use has an incidental health benefit.

16. Effective Date is the date on which coverage of a members begins under this plan according to the schedule of eligibility.

17. An emergency is the sudden onset of a medical condition of sufficient severity that, in the absence of immediate medical attention, could result in any of the following:

    a. Permanently placing a member's health in jeopardy;
    b. Causing other serious medical consequences;
    c. Causing serious impairments to body functions; or
    d. Causing serious or permanent dysfunction of any body organ or part.

18. Experimental and investigative refers to the use of any treatment, drug, procedure or supply which, in Contractor's judgment, is not yet recognized as acceptable medical practice or which requires but has not received approval by a Federal or other governmental agency.

19. Explanation of Benefits is the form we send after a claim has been filed that tells you what services were covered and which, if any, were not.

20. Family coverage provides benefits for the subscriber and one or more eligible dependents.

21. Family Deductible is the maximum dollar amount of Covered Services stated in the Schedule of Benefits that must be incurred and paid by a Subscriber and his or her eligible Dependents before benefits are payable for all or part of the remaining Covered Services.

22. Family Out-of-Pocket Maximum means the maximum dollar amount stated in the Schedule of Benefits for which a Subscriber and his or her covered eligible Dependents are responsible to pay for Covered Services during a Benefit Period. This Maximum can be satisfied by a

combination of services provided by Blue Preferred and non-Blue Preferred provider. Refer to Paragraph 39 for more information.

23. Fee Schedule or Fee for Services refers to the maximum fee that BCBST will pay for specified Covered Services.

24. Health Care Professional means a podiatrist, dentist, chiropractor, nurse midwife, registered nurse, optometrist, or other person licensed or certified to practice a health care profession, other than medicine or osteopathy, by Tennessee or the state in which such provider practices.

25. A home health care agency means a public agency or private organization that provides services in a member's home.

26. Hospice means a public agency or private organization that provides services for a terminally ill patient in a home environment.

27. Hospital means a short-term, acute, general Hospital which:

    a) Is a licensed acute care Institution accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), or Medicare certified;

    b) Provides Inpatient services and is compensated by or on behalf of its patients;

    c) Provides surgical and medical facilities primarily to diagnose, treat, and care for the injured and sick, except that a psychiatric hospital will not be required to have surgical facilities;

    d) Has a staff of Physicians licensed to practice medicine; and

    e) Provides 24-hour nursing care by registered graduate nurses.

    * A facility which serves, other than incidentally, as a nursing home, custodial care home, health resort, rest home, rehabilitation facility, or place for the aged is not considered a Hospital.

28. Host Plan is a Blue Cross Blue Shield organization that has a contract with a provider that provides services to its subscribers outside of the contractor service area.

29. An Inpatient is a Member treated as a bed patient in a Hospital or Facility-Other-Provider and who incurs a room and board charge.

30. Maximum Allowable Charge means the highest dollar amount of reimbursement by BCBST for a particular Covered Service. Such amount is based on the rates or fees negotiated between BCBST and

certain Physicians, Health Care Professionals, or other providers, and whether Services are received from a Blue Preferred or Non-Blue Preferred Provider.

31. Medical Care means professional services by a Physician or Professional-Other-Provider to treat an illness, injury, pregnancy, or other medical condition.

32. Medically Necessary

    a. A service is Medically Necessary if, in the discretion of BCBST, it is:

        1. Consistent with the symptoms or diagnosis of the Member's condition, disease, ailment, or injury;

        2. Appropriate with regard to standards of good medical practice;

        3. Not primarily for the convenience of a Member, Physician, Hospital or Other Provider; and

        4. The most appropriate supply or level of service which can safely be provided to the Member. When applied to the care of an Inpatient, it further means that the Member's medical condition requires that services cannot be safely provided to the Member as an Outpatient.

    b) When applied to services for Private Duty Nursing, it further means that the services require the skills of a Registered Nurse, or Licensed Practical Nurse.

    c) The fact that a Physician has prescribed, performed, ordered, recommended, or approved a service does not, in and of itself, mean that BCBST considers it Medically Necessary.

33. A member is the subscriber and any eligible dependent, provided family coverage is in force. A member has all the rights and privileges stated in the Plan.

34. Nervous and Mental Disorder means a condition characterized by abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional, or behavioral disturbances are the dominant feature. Nervous and Mental Disorders include mental disorders, mental illnesses, psychiatric illnesses, mental conditions, and psychiatric conditions, whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement.

35. Non-Covered Charge is the amount of total charge that is not eligible for consideration of payment.

36. Non-Participating Provider means a physician, hospital, or other provider that has not contracted with contractor to furnish services and to accept Contractor's payment, plus applicable deductibles and Co-Payments in full for covered Services.

37. The following institutions are Facility Other Providers for the purpose of providing Covered Services under this Contract:

    a) Freestanding Dialysis Facility;

    b) Ambulatory Surgical Facility;

    c) Skilled Nursing Facility;

    d) Substance Abuse Treatment Facility;

    e) Residential Treatment Facility; and

    f) State Approved Birthing Centers.

38. The following Professional-Other-Providers may provide services covered by this Contract. In order to be covered, all services rendered must fall within a specialty (as defined below) and be those normally provided by a Provider within this specialty or degree. All services or supplies must be rendered by the Provider actually billing for them and be within the scope of his or her License.

    a) Doctor of Osteopathy (D.O);

    b) Doctor of Dental Surgery (D.D.S.);

    c) Doctor of Dental Medicine (D.M.D.);

    d) Doctor of Optometry (O.D.);

    e) Doctor of Pediatric Medicine (D.P.M.);

    f) Licensed clinical, counseling, of school psychologist;

    g) Registered nurse (R.N.)

    h) Registered nurse anesthetist (R.N.A.);

    i) Licensed practical nurse (L.P.N.);

    j) Nurse Practitioner (Certified by nationally recognized accrediting body);

k) Licensed Pharmacist (D. Pharm):

l) Licensed registered nurse midwife when services are provided in a State Approved birthing center;

m) Registered occupational therapist (only for cases indicated);

n) Registered speech therapist (only for cases indicated);

o) Licensed clinical social worker;

p) Licensed Professional Counselor-Mental Health Service Providers (LPC-MHSP);

q) Certified registered nurse anesthetist (C.R.N.A); and

r) Physician's Assistants.

39. The following Other Providers may also provide services covered under this Contract:

a) Suppliers of Durable Medical Equipment, appliances and prosthesis;

b) Suppliers of oxygen;

c) Certified ambulance service;

d) Hospice;

e) Pharmacy;

f) Freestanding Diagnostic Laboratory; and

g) Home Health Care Agency.

40. Out-of-pocket maximum means the maximum dollar amount stated in the Benefits Summary for which a member is responsible to pay for covered services during a benefit period. This will not include any charges in excess of the allowable maximum allowable charge or penalty paid for not following the pre-admission certification procedure.

a. When an employee receives services from an in-network provider, benefits will be payable at 100 percent maximum allowable charge (MAC) after the in-network maximum has been met for the year.

b. Likewise, when an employee receives services from an out-of-network provider, benefits will be payable at 100 percent MAC after the out-of-network maximum has

been met for the year. An out-of-service-area employee will receive payments at 100 percent MAC after the out-of-service-area maximum has been met.

c. Other Services (e.g., ambulance service, medical equipment, and certain routine immunizations) will be subject to the in-network out-of-pocket maximum for all Plan participants.

d. Only eligible expenses apply to the out-of-pocket maximum; non-covered charges, such as charges in excess of the negotiated rate or reductions made for failure to get pre-certification for non-network providers, do not apply to the maximum.

41. An Outpatient is a Member who receives services or supplies on other than an Inpatient basis.

42. Outpatient Surgery means Surgery performed in an Outpatient department of a Hospital, Physician's office, or Facility Other Provider.

43. Participating Provider refers to an institution, outpatient mental health facility, outpatient physical therapy facility, home health agency, pharmacy, or other provider of health care services, which, at the time the member receives covered services has an agreement with contractor (or entity contracting with contractor) to provide those health care services to members under this plan. A participating provider may bill or seek reimbursement for authorized services from contractor, except for the member's deductibles, co-payments or coinsurance amounts.

44. A pre-existing condition is an illness or injury, which was diagnosed by a provider to a member before the subscriber's coverage was effective under the benefit plan description.

45. "Pre-Existing Condition Waiting Period" means the period stated in the Benefits Summary (beginning with the Effective Date of coverage under this Contract) during which services rendered in connection with a Pre-Existing Condition are not payable.

46. A provider is a hospital, physician, or other eligible provider performing within the scope of an applicable license.

    a) A network provider is a designated institution, physician, or other provider within the designated service area who has an agreement with Contractor.

    b) A non-network provider is one which does not have such an agreement.

47. Psychiatric care is treatment of a Nervous or Mental Disorder (as defined by Paragraph 21 of this Section). Psychiatric Care includes treatment for drug addiction or alcoholism.

48. Rehabilitation is defined as "A creative procedure which includes cooperative efforts of various medical specialties to improve the mental, physical, social and vocational aptitudes of persons who are handicapped."

49. A Residential Treatment Facility means a Facility-Other-Provider primarily engaged in providing detoxification and rehabilitation treatment for alcoholism and drug abuse. A Residential Treatment Facility must be licensed, accredited by the Joint Commission on Accreditation of Healthcare Organizations, and be recognized by BCBST.

50. Service Area includes those geographic areas in which covered services from participating providers are available.

51. A Skilled Nursing Facility provides convalescent and rehabilitative care on an Inpatient basis. Skilled nursing care must be provided by or under the supervision of a Physician, and the following are not to be considered a skilled nursing facility under this contract:

    a) A facility which primarily provides minimal, custodial, ambulatory, or part time care; or

    b) A facility which treats mental illness, alcoholism, drug abuse, or pulmonary tuberculosis.

52. A Special Care Unit is the areas of a hospital where necessary supplies, medications, equipment, and a skilled staff are available to provide care to critically or seriously ill patients who require constant observation.

53. Subrogation, as explained in Section IV, paragraph J, refers to Contractor's right to recover on behalf of this Plan any payments for medical expenses paid by the Plan because a member became ill or was injured by the action or fault of another person when payments are made by the person who caused the illness or injury, or his or her insurance plan.

54. A subscriber is:

    a) An annual, full-time or part-time employee (scheduled to work 16 hours or more per week)

    b) An annual, full-time or part-time employee (working 16 hours or more per week) of the unions directly representing TVA salary policy employees; or

    c) A retiree (as defined elsewhere in this Section) who is not eligible for Medicare hospital insurance; or

    d) A retired employee of the unions directly representing TVA salary policy employees who is not eligible for Medicare hospital insurance.

55. A substance abuse treatment facility provides a continuous, structured 24-hour per day program of inpatient treatment and rehabilitation for drug dependency or alcoholism. A substance abuse treatment facility must be licensed to provide this type of care by the State in

which it operates and be approved by Contractor. Substance abuse treatment facility must be approved by Joint Commission on Accreditation of Healthcare Organizations.

56. Therapy services are used to treat an illness or injury. They include, but are not limited to:

a. Radiation therapy—treatment of disease by X-ray, radium, or radioactive isotopes;

b. Chemotherapy—treatment of malignant disease by chemical or biological agents;

c. Dialysis—treatment of a kidney ailment, including the use of an artificial kidney machine;

d. Physical therapy—treatment to relieve pain, restore bodily function, and prevent disability following illness, injury, or loss of a body part. It may include physical means, hydrotherapy, heat, physical agents, bio-mechanical, and neuro-physiological principles, and other devices;

e. Respiratory therapy—introduction of dry or moist gases into the lungs;

f. Occupational therapy and hand therapy (in cases of stroke or injury cases) - medically directed treatment of physically and/or mentally disabled individuals by means of constructive activities designed and adapted by a professionally qualified occupational therapist to promote the restoration of useful function;

g. Speech therapy (in cases of stroke or accidental brain injury cases)—the study, examination, appreciation and treatment of defects and diseases of the voice, of speech and of spoken and written language, as well as the use of appropriate substitute devices and treatment; and

h. Vision therapy—treatment of eye muscle deficiencies by use of exercises or mechanical means (other than glasses or contact lenses).